

ATTORNEY OF PARTY WITHOUT ATTORNEY (Name, State Bar number, and address):

JOHN P. ROSENBERG

77946

JOHN P. ROSENBERG

6355 TOPANGA CANYON BLVD., STE. 515

WOODLAND HILLS, CA 91367

TELEPHONE: (818) 716-6400

ATTORNEY FOR (Name):

L.A. SUPERIOR COURT/VAN NUYS

STREET ADDRESS: per rule 982.9 (a) (8):

MAILING ADDRESS: the address of the court is not required

CITY AND ZIP CODE:

BRANCH NAME: L.A. SUPERIOR COURT/VAN NUYS

FOR COURT USE ONLY

Plaintiff

GOLD

Defendant

EGGLETON

CASE NUMBER:

11V05219

Ref. or File No.:

14-11920825

## Declaration of Diligence

I received the within process on 09/08/11 and that after due and diligent effort, I have been unable to effect personal service on the within named party. Dates and times of attempts with reported details are listed below. Costs for diligence pertaining to substituted service is recoverable under C.C.P. 1033.5(a) (4) (B).

Servee: GRANT EGGLETON

Home address: 675 BENNET STREET  
Simi Valley CA 93065

Business address:

09/13/11 11:27am No answer at residence on current attempt  
09/15/11 9:19pm No answer at residence on current attempt  
09/17/11 9:51am No answer at residence on current attempt  
09/20/11 11:01am No answer at residence on current attempt  
09/23/11 5:50pm No answer at residence on current attempt  
09/26/11 8:59am SUBSTITUTED SERVICE. RECIPIENT INSTRUCTED TO DELIVER DOCUMENTS TO DEFENDANT

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Person serving (name, address, and telephone No.):

40011

J. RIOS

7124 Owensmouth Ave., #106,

Canoga Park CA 91303

(213) 928-7247

Fee for service: \$ 71.95

(recoverable per C.C.P. 1033.5(a) (4) (B))

☐ Not a registered California process server.☐ Exempt from registration under B&P 22350(b).☒ Registered California process server.

(1) Employee or independent contractor.

(2) Registration No.: 523

(3) County: VENTURA

Date: 09/29/11

(Signature)

Form Adopted by rule 982

Declaration of Diligence

982.9 (a) (5)

14-11920825

GO: 14

Plaintiff (list names): GOLD, KATHY

**(4) You must ask the Defendant (in person, in writing, or by phone) to pay you before you sue.**

**Have you done this?** ☒ Yes ☐ No

*If no, explain why not:*

**(5) Why are you filing your claim at this courthouse?**

**This courthouse covers the area** *(Check the one that applies):*

a. ☒ (1) Where the Defendant lives or does business.

(2) Where the Plaintiff's property was damaged.

(3) Where the Plaintiff was injured.

(4) Where a contract (written or spoken) was made, signed, performed, or broken by the Defendant or where the Defendant lived or did business when the Defendant made the contract.

b. ☐ Where the buyer or lessee signed the contract, lives now, or lived when the contract was made, if this claim is about an offer or contract for personal, family, or household goods, services, or loans. *(Code Civ. Proc., 395(b).)*

c. ☐ Where the buyer signed the contract, lives now, or lived when the contract was made, if this claim is about a retail installment contract (like a credit card). *(Civil Code, 1812.10.)*

d. ☐ Where the buyer signed the contract, lives now, or lived when the contract was made, or where the vehicle is permanently garaged, if this claim is about a vehicle finance sale. *(Civil Code, 2984.4.)*

e. ☐ Other *(specify):*

**(6) List the zip code of the place checked in (5) above** *(if you know):* 91423

**(7) Is your claim about an attorney-client fee dispute?** ☐ Yes ☒ No

*If yes, and if you have had arbitration, fill out Form SC-101, attach it to this form and check here:* ☐

**(8) Are you suing a public entity?** ☐ Yes ☒ No

*If yes, you must file a written claim with the entity first.* ☐ A claim was filed on *(date):*

*If the public entity denies your claim or does not answer within the time allowed by law, you can file this form.*

**(9) Have you filed more than 12 other small claims within the last 12 months in California?**

☐ Yes ☒ No *If yes, the filing fee for this case will be higher.*

**(10) I understand that by filing a claim in small claims court, I have no right to appeal this claim.**

**(11) I have not filed, and understand that I cannot file, more than two small claims cases for more than \$2,500 in California during this calendar year.**

I declare, under penalty of perjury under California State law, that the information above and on any attachments to this form is true and correct.

Date: 09/02/2011

\_\_\_\_\_  
*Plaintiff types or prints name here*

\_\_\_\_\_  
*Plaintiff signs here*

Date:

\_\_\_\_\_  
*Second Plaintiff types or prints name here*

\_\_\_\_\_  
*Second Plaintiff signs here*

**Requests for Accommodations**

Assistive listening systems, computer-assisted, real-time captioning, or sign language interpreter services are available if you ask least 5 days before the trial. Contact the clerk's office for Form MC-410, *Request for Accommodations by Persons With Disabilities and Response.* *(Civil Code, 54.8.)*

# **SC-100** **Plaintiff's Claim and ORDER to Go to Small Claims Court**

## **Notice to the person being sued:**

- You are the Defendant if your name is listed in (2) on page 2 of this form. The person suing you is the Plaintiff, listed in (1) on page 2.
- You and the Plaintiff must go to court on the trial date listed below. If you do not go to court, you may lose the case.
- If you lose, the court can order that your wages, money, or property be taken to pay this claim.
- Bring witnesses, receipts, and any evidence you need to prove your case.
- Read this form and all pages attached to understand the claim against you and to protect your rights.

## **Aviso al Demandado:**

- Usted es el Demandado si su nombre figura en (2) de la pagina 2 de este formulario. La persona que lo demanda es el Demandante, la que figura en (1) de la pagina 2.
- Usted y el Demandante tienen que presentarse en la corte en la fecha del juicio indicada a continuacion. Si no se presenta, puede perder el caso.
- Si pierde el caso la corte podria ordenar que le quiten de su sueldo, dinero u otros bienes para pagar este reclamo.
- Lleve testigos, recibos y cualquier otra prueba que necesite para probar sucaso.
- Lea este formulario y todas las paginas adjuntas para entender la demanda en su contra y para proteger sus derechos.

Clerk stamps date here when form is filed.

FILED  
LOS ANGELES SUPERIOR COURT

SEP 02 2011

John A. Clark, Executive Officer/Clerk

BY SANDRA ALARCON, DEPUTY

Fill in court name and street address:

Superior Court of California, County of  
Los Angeles: NORTHWEST DISTRICT (-19498- )  
VAN NUYS COURTHOUSE EAST  
6230 SYLMAR AVENUE  
VAN NUYS, CA. 91401  
(818) 374-2901

Clerk fills in case number and case name:

Case Number:  
LAV 11V05219  
Case Name:  
GOLD, KATHY VS EGGLETON, GRAN

## **Order to Go to Court**

The people in (1) and (2) must go to court: (Clerk fills out section below.)

TRIAL DATE	DATE	TIME	DEPARTMENT	LOCATION
	10/18/2011	08:30 AM	NWZ	ROOM 320, THIRD FL

Date: 09/02/2011      JOHN A. CLARKE, Executive Officer/Clerk  
By SANDRA ALARCON      , Deputy

## **Instructions for the person suing:**

- You are the Plaintiff. The person you are suing is the Defendant.
- Before you fill out this form, read Form SC-100-INFO, Information for the Plaintiff to know your rights. Get SC-100-INFO at any courthouse or county law library, or go to: [www.courtinfo.ca.gov/forms](http://www.courtinfo.ca.gov/forms)
- Fill out pages 2 and 3 of this form. Then make copies of all pages of this form. (Make 1 copy for each party named in this case and an extra copy for yourself.) Take or mail the original and these copies to the court clerk's office and pay the filing fee. The clerk will write the date of your trial in the box above.
- You must have someone at least 18--not you or anyone else listed in this case--give each Defendant a court-stamped copy of all 5 pages of this form and any pages this form tells you to attach. There are special rules for "serving," or delivering, this form to public entities, associations, and some businesses. See Forms SC-104, SC-104B, and SC-104C.
- Go to court on your trial date listed above. Bring witnesses, receipts, and any evidence you need to prove your case.

**SC-100****Plaintiff's Claim and ORDER  
to Go to Small Claims Court****Notice to the person being sued:**

- You are the Defendant if your name is listed in (2) on page 2 of this form. The person suing you is the Plaintiff, listed in (1) on page 2.
- You and the Plaintiff must go to court on the trial date listed below. If you do not go to court, you may lose the case.
- If you lose, the court can order that your wages, money, or property be taken to pay this claim.
- Bring witnesses, receipts, and any evidence you need to prove your case.
- Read this form and all pages attached to understand the claim against you and to protect your rights.

**Aviso al Demandado:**

- Usted es el Demandado si su nombre figura en (2) de la página 2 de este formulario. La persona que lo demanda es el Demandante, la que figura en (1) de la página 2.
- Usted y el Demandante tienen que presentarse en la corte en la fecha del juicio indicada a continuación. Si no se presenta, puede perder el caso.
- Si pierde el caso la corte podría ordenar que le quiten de su sueldo, dinero u otros bienes para pagar este reclamo.
- Lleve testigos, recibos y cualquier otra prueba que necesite para probar su caso.
- Lea este formulario y todas las páginas adjuntas para entender la demanda en su contra y para proteger sus derechos.

**Order to Go to Court**

**The people in (1) and (2) must go to court:** (Clerk fills out section below.)

Trial Date	Date	Time	Department	Name and address of court if different from above
1.	10-18-11	8:30	2	NORTHWEST DISTRICT - EAST BLDG.
2.				6230 SYLMAR AVENUE
3.	9-2-11			VAN NUYS, CA 91401
Date:			Clerk, by: JOHN A. CLARKE, Deputy	

**Instructions for the person suing:**

- You are the Plaintiff. The person you are suing is the Defendant.
- Before you fill out this form, read Form SC-100-INFO, *Information for the Plaintiff*, to know your rights. Get SC-100-INFO at any courthouse or county law library, or go to: [www.courtinfo.ca.gov/forms](http://www.courtinfo.ca.gov/forms)
- Fill out pages 2 and 3 of this form. Then make copies of all pages of this form. (Make 1 copy for each party named in this case and an extra copy for yourself.) Take or mail the original and these copies to the court clerk's office and pay the filing fee. The clerk will write the date of your trial in the box above.
- You must have someone at least 18—not you or anyone else listed in this case—give each Defendant a court-stamped copy of all 5 pages of this form and any pages this form tells you to attach. There are special rules for "serving," or delivering, this form to public entities, associations, and some businesses. See Forms SC-104, SC-104B, and SC-104C.
- Go to court on your trial date listed above. Bring witnesses, receipts, and any evidence you need to prove your case.

Clerk stamps date here when form is filed.

**FILED**  
LOS ANGELES SUPERIOR COURT

SEP 02 2011

John A. Clark, Executive Officer/Clerk

BY SANDRA ALARCON, DEPUTY

Fill in court name and street address:

Superior Court of California, County of  
LOS ANGELES  
Los Angeles Superior Cou  
6230 Sylmar Avenue  
same  
Van Nuys, California 914  
NORTHWEST DISTRICT

Clerk fills in case number and case name:

Case Number:

11V 05219

Case Name:

GOLD v. EDDLETON

Case Number:

Plaintiff (list names): KATHY GOLD

**1 The Plaintiff (the person, business, or public entity that is suing) is:**

Name: KATHY GOLD Phone: ( 818 ) 358-3865

Street address: c/o 6355 Topanga Canyon Blvd #515, Woodland Hills, CA 91367  
Street City State Zip

Mailing address (if different):  
Street City State Zip

**If more than one Plaintiff, list next Plaintiff here:**

Name: Phone: ( )

Street address:  
Street City State Zip

Mailing address (if different):  
Street City State Zip

☐ Check here if more than 2 Plaintiffs and attach Form SC-100A.

☐ Check here if either Plaintiff listed above is doing business under a fictitious name. If so, attach Form SC-103.

**2 The Defendant (the person, business, or public entity being sued) is:**

Name: GRANT EGGLETON Phone: ( 310 ) 889-4987

Street address: 675 Bennet Street Simi Valley, CA 93065  
Street City State Zip

Mailing address (if different):  
Street City State Zip

**If more than one Defendant, list next Defendant here:**

Name: Phone: ( )

Street address:  
Street City State Zip

Mailing address (if different):  
Street City State Zip

☐ Check here if more than 2 Defendants and attach Form SC-100A.

☐ Check here if any Defendant is on active military duty, and write his or her name here: \_\_\_\_\_

**3 The Plaintiff claims the Defendant owes \$ 7,500.00 . (Explain below):**

a. Why does the Defendant owe the Plaintiff money? Defendant rear-ended Plaintiff on the 101 freeway near Woodman Avenue, Sherman Oaks, California, causing Plaintiff bodily injuries requiring medical care.

b. When did this happen? (Date): 11-16-10

If no specific date, give the time period: Date started: Through:

c. How did you calculate the money owed to you? (Do not include court costs or fees for service.) see attached SC-100.

☐ Check here if you need more space. Attach one sheet of paper or Form MC-031 and write "SC-100, Item 3" at the top.

Plaintiff (list names): KATHY GOLD

- ④ You must ask the Defendant (in person, in writing, or by phone) to pay you before you sue. Have you done this? ☒ Yes ☐ No

If no, explain why not: \_\_\_\_\_

- ⑤ Why are you filing your claim at this courthouse?

This courthouse covers the area (check the one that applies):

- a. ☒ (1) Where the Defendant lives or does business. (2) Where the Plaintiff's property was damaged. (3) Where the Plaintiff was injured. (4) Where a contract (written or spoken) was made, signed, performed, or broken by the Defendant or where the Defendant lived or did business when the Defendant made the contract.
- b. ☐ Where the buyer or lessee signed the contract, lives now, or lived when the contract was made, if this claim is about an offer or contract for personal, family, or household goods, services, or loans. (Code Civ. Proc., § 395(b).)
- c. ☐ Where the buyer signed the contract, lives now, or lived when the contract was made, if this claim is about a retail installment contract (like a credit card). (Civil Code, § 1812.10.)
- d. ☐ Where the buyer signed the contract, lives now, or lived when the contract was made, or where the vehicle is permanently garaged, if this claim is about a vehicle finance sale. (Civil Code, § 2984.4.)
- e. ☐ Other (specify): \_\_\_\_\_

- ⑥ List the zip code of the place checked in ⑤ above (if you know): 91423

- ⑦ Is your claim about an attorney-client fee dispute? ☐ Yes ☒ No

If yes, and if you have had arbitration, fill out Form SC-101, attach it to this form, and check here: ☐

- ⑧ Are you suing a public entity? ☐ Yes ☒ No

If yes, you must file a written claim with the entity first. ☐ A claim was filed on (date): \_\_\_\_\_

If the public entity denies your claim or does not answer within the time allowed by law, you can file this form.

- ⑨ Have you filed more than 12 other small claims within the last 12 months in California?

☐ Yes ☒ No If yes, the filing fee for this case will be higher.

- ⑩ I understand that by filing a claim in small claims court, I have no right to appeal this claim.

- ⑪ I have not filed, and understand that I cannot file, more than two small claims cases for more than \$2,500 in California during this calendar year.

I declare, under penalty of perjury under California State law, that the information above and on any attachments to this form is true and correct.

Date: 8/22/11 KATHY GOLD

Plaintiff types or prints name here


  
Plaintiff signs here

Date: \_\_\_\_\_

Second Plaintiff types or prints name here


  
Second Plaintiff signs here
**Requests for Accommodations**

Assistive listening systems, computer-assisted, real-time captioning, or sign language interpreter services are available if you ask at least 5 days before the trial. Contact the clerk's office for Form MC-410, Request for Accommodations by Persons With Disabilities and Response. (Civil Code, § 54.8.)

PETITIONER/PLAINTIFF: KATHY GOLD  
RESPONDENT/DEFENDANT: GRANT EGGLETON

CASE NUMBER:

SC-100, Item 3

3(c) Medical Bills: Orthopedic Medical Center	\$1,568.00
Valley PT & Rehab	\$2,795.00
Prescription Charges	33.88
TOTAL MEDICAL BILLS	<u>\$4,396.88</u>
General Damages for pain and suffering	\$3,103.12



**Ambulatory Care Network**  
HEALTH SERVICES • LOS ANGELES COUNTY

**MID-VALLEY COMPREHENSIVE HEALTH CENTER RELEASE OF INFORMATION**

7515 Van Nuys Blvd  
Van Nuys, CA 91405  
Office - 1(818)947-4044  
FAX- 1(818)989-8858

**INVOICE**

Attached are the photo copies you requested regarding:

Date: 10/30/15

Patient Name	GOLD, Kathleen	MV Medical Record	233-35-41	DOB	12/17/1966
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Our photocopy fee is \$0.25 per page				
Pages copied	11	x .25	= Total amount due for these copies	\$2.75

);

County of Los Angeles  
Olive View/UCLA Medical Center  
14445 Olive View Drive  
Sylmar, CA 91342  
(818) 364-3189

Comprehensive Health Center  
Van Nuys Blvd.  
CA 91405  
Medical Records Dept.  
# 95-6000927W

PAID OCT 30 2015  
R# 732758  
AT

Date: 10/30/2015 Receipt: 732758

NAME: GOLD, KATHLEEN/2333541

ITEM: SALE OF PHOTOCOPIES

Total Payment: 2.75

Payment Form: CHECK

Health Center -Release of Information Dept.

\*\*\* Thank You \*\*\*  
CA

, 7515 Van Nuys Blvd., Van Nuys, CA 91405; (818) 947-4044



**Ambulatory Care Network**  
HEALTH SERVICES • LOS ANGELES COUNTY

**MID-VALLEY COMPREHENSIVE HEALTH CENTER RELEASE OF INFORMATION**

7515 Van Nuys Blvd  
Van Nuys, CA 91405  
Office - 1(818)947-4044  
FAX- 1(818)989-8858

## INVOICE

Attached are the photo copies you requested regarding:

Date: 10/30/15

Patient Name	GOLD, Kathleen	MV Medical Record	233-35-41	DOB	12/17/1966
--------------	----------------	-------------------	-----------	-----	------------

Our photocopy fee is \$0.25 per page

Total pages copied	11	x .25	= Total amount due for these copies	\$2.75
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Please make check payable to:

Mid-Valley Comprehensive Health Center  
7515 Van Nuys Blvd.  
Van Nuys, CA 91405  
Attn: Medical Records Dept.  
**TAX ID# 95-6000927W**

PAID OCT 30 2015  
R# 732758  
at

Thank You,  
Mid-Valley Comprehensive Health Center -Release of Information Dept.

Mid-Valley Comprehensive Health Center, 7515 Van Nuys Blvd., Van Nuys, CA 91405; (818) 947-4044

# Exhibit A - Landini

COUNTY OF LOS ANGELES

DEPARTMENT OF HEALTH SERVICES

## AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

MEDICAL RECORD NUMBER: \_\_\_\_\_ DATE: 10-21-15

RELATIONSHIP TO PATIENT: ☒ SELF ☐ PARENT ☐ LEGAL GUARDIAN ☐ OTHER: \_\_\_\_\_

### Patient Information

☒ Go LD Last Name Kathleen First Marie MI AS12 Date of Birth 12/17/66  
☒ 11100-8 Sepulveda Blvd Address Mission Hills City 91345 State CA Zip (818) 235-6370 Phone

### HEREBY AUTHORIZES

- |   |   |
|---|---|
| <input type="checkbox"/> LAC+USC Medical Center     | <input type="checkbox"/> Rancho Los Amigos National Rehabilitation Center             |
| <input type="checkbox"/> Olive View Medical Center  | <input type="checkbox"/> High Desert Multi-Service Ambulatory Care Center             |
| <input type="checkbox"/> Harbor-UCLA Medical Center | <input type="checkbox"/> Martin Luther King, Jr. Multi-Service Ambulatory Care Center |
| <input type="checkbox"/> CHC/Health Center:         |   |

☒ Other: MVHC Facility Name Street Address City State Zip Code

### To Release Protected Health Information To:

SELF - Call to P/U

Name of Facility/Health Care Provider/Plan/Other Street Address City State Zip Code

for the time period beginning, All Records Date, and ending 10/21/15 Date

EXPIRATION DATE: This authorization is valid until the following date: 4/21/2016

### INFORMATION TO BE DISCLOSED

#### PLEASE CHECK ALL APPROPRIATE BOXES:

- |  |   |
|--|---|
| <input type="checkbox"/> Discharge Summary             | <input type="checkbox"/> Mental Illness or Mental Health Assessment |
| <input type="checkbox"/> History and Physical          | <input type="checkbox"/> Drug and/or Alcohol Abuse Treatment        |
| <input type="checkbox"/> Consultation                  | <input type="checkbox"/> HIV/AIDS                                   |
| <input type="checkbox"/> Operative Report              | <input type="checkbox"/> Sexually Transmitted Disease(s)            |
| <input type="checkbox"/> Radiology Report              | <input type="checkbox"/> EKG Report                                 |
| <input type="checkbox"/> Radiology Films               | <input type="checkbox"/> EEG Report                                 |
| <input type="checkbox"/> Laboratory / Diagnostic Tests | <input type="checkbox"/> Summary of Medical History / Treatment     |
| <input type="checkbox"/> Medical Progress Notes        |   |

☒ Other (Please Specify): All Records

MID-VALLEY COMP. - CENTER PATIENT IDENTIFICATION  
233 35 41 DOB: 12/17/1966  
GOLD, KATHLEEN PHWR  
PREF. LANG: ENGLISH SEX: F

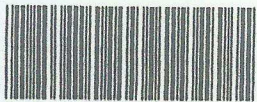


MRUN 233-35-41

NAME Gold, Kathleen

DOB/GENDER 12/17/1966 F

AUTHORIZATION FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION



T-HS1015

FILE IN MEDICAL RECORD

## THE PURPOSE OF THE DISCLOSURE - PROVIDE A DESCRIPTION OF THE PURPOSE OF INTENDED USE AND DISCLOSURE

Personal

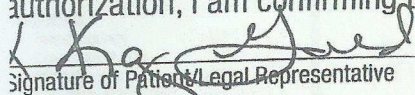
understand that health information used or disclosed as a result of my signing this Authorization may not be further used or disclosed by the recipient unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

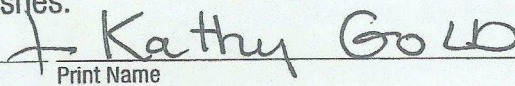
**YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:**

**Right to Receive a Copy of This Authorization** - I understand that if I sign this authorization, I will be provided with a signed copy of the form.

**CONDITIONS:** I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment. However, DHS may condition the provision of research-related treatment on obtaining an authorization to use or disclose protected health information created for that research-related treatment. (In other words, if this authorization is related to research that includes treatment, you will not receive that treatment unless this authorization form is signed.)

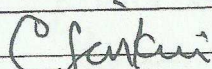
I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

  
Signature of Patient/Legal Representative

  
Print Name

If signed by other than the patient, state relationship and authority to do so:

Date: 10/21/15

Witness: 

Print Name: C Jenkins

**Right to Revoke This Authorization** - I understand that I have the right to revoke this Authorization at any time by telling DHS in writing. I may use the Revocation of Authorization at the bottom of this form. Mail of deliver the revocation to the following facility address:

I also understand that a revocation will not affect the ability of DHS or any health care provider to use or disclose the health information for reasons related to the prior reliance on this Authorization.

**REVOCATION OF AUTHORIZATION**

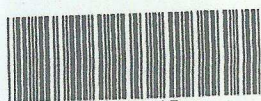
Signature of Patient/Legal Representative:

If signed by other than patient, state relationship and authority to do so:

MR/UN

NAME

DOB/GENDER



T-HS1015

FILE IN MEDICAL RECORD

AUTHORIZATION FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION

PAGE 2 OF 2

HS1015 (4-14)

**AMBULATORY CARE NETWORK**  
MID-VALLEY CHC, SAN FERNANDO AND GLENDALE HEALTH CENTERS, VAUGHN SBC

Abnormal NO MARK=NOT EXAMINED  
(N=Normal or No significant findings.)

**GENERAL APPEARANCE**  
Appearance ☒ N ☐ A  
Adenopathy ☒ N ☐ A

**HEAD**  
Scalp ☐ N ☐ A  
Ears - External ☐ N ☐ A  
Internal ☐ N ☐ A  
Eyes-General ☐ N ☐ A  
Fundoscopic ☐ N ☐ A  
Oral cavity ☐ N ☐ A

**NECK**  
Thyroid ☐ N ☐ A

**THORAX, AND**  
Chest Wall ☐ N ☐ A

**HEART**  
PMI ☒ N ☐ A  
Rate / Rhythm ☒ N ☐ A  
Murmur ☒ N ☐ A  
Gallop ☐ N ☐ A  
JVP ☐ N ☐ A

**LUNGS**  
Auscultation ☒ N ☐ A  
Percussion ☐ N ☐ A  
Excursions ☐ N ☐ A

**BREASTS**  
Skin changes ☐ N ☐ A  
Nipple / Areola ☐ N ☐ A  
Axilla ☐ N ☐ A  
Masses ☐ N ☐ A

**ABDOMEN**  
Bowel Sounds ☒ N ☐ A  
Liver/Spleen Size ☒ N ☐ A  
Masses ☒ N ☐ A  
Abdomen Tenderness ☒ N ☐ A  
CVA tenderness ☒ N ☐ A

**MUSCULOSKELETAL**  
Extremities ☒ N ☐ A  
Clubbing ☒ N ☐ A  
Cyanosis ☒ N ☐ A  
Edema ☒ N ☐ A  
Joints ☒ N ☐ A  
Back ☒ N ☐ A

**FOOT EXAM** ☐ N ☐ A

**VASCULAR SYSTEM**  
Carotids ☐ N ☐ A  
Abdominal Aorta ☐ N ☐ A  
Femorals ☐ N ☐ A  
Posterior tibials ☐ N ☐ A

**GENITALIA**  
**Male**  
Penis ☐ N ☐ A  
Testicles & epididymis ☐ N ☐ A  
**Female**  
External Genitalia ☐ N ☐ A  
Vagina ☐ N ☐ A  
Cervix ☐ N ☐ A  
Uterus ☐ N ☐ A  
Adnexa ☐ N ☐ A

**ANORECTAL**  
External Appearance ☐ N ☐ A  
Digital Exam ☐ N ☐ A  
Prostate Gland ☐ N ☐ A

**NEUROLOGICAL**  
Alertness & orientation ☐ N ☐ A  
Cranial nerves (I-XII) ☐ N ☐ A  
Motor ☐ N ☐ A  
Sensory ☐ N ☐ A  
DTR ☐ N ☐ A  
Cerebellar ☐ N ☐ A  
Memory ☐ N ☐ A  
Speech ☐ N ☐ A

(See over for Assessment, Plan, Orders)

**Nursing Intake**

BP	Temp	HR	RR	*Pain Level	Pain Goal	Pain Tool	Pain Location
119/53	98.3	74	16	0/10	0/10	0-10 Faces	<input type="checkbox"/> Back <input type="checkbox"/> Head Other:

WEIGHT: 188 HEIGHT: BMI: LMP: Allergies: NKDA  
Currently Smoking: ☒ Yes ☐ No

Reason for visit: (Circle Applicable):	New / IHA	Return	Same Day	Interpreter
<b>Annual Fall Assessment:</b>				
1. Has there been an unexpected fall in the preceding 3 months?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			<input type="checkbox"/> Provided
2. Does patient have an unstable gait (with or without assistance / assistive device)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			<input type="checkbox"/> Declined
3. Does patient have any changes in vision, strength or sensation/loss of feeling?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			<input checked="" type="checkbox"/> N/A
4. Is patient on meds that may lead to fall risk (e.g. narcotics or cardiac-related drugs)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
If any of the questions 1 to 4 is marked as "yes" - Fall precaution taken and education provided <input type="checkbox"/> Yes				
Signature: Luisa Arellano CMA NA/CMA/LVN / RN Date/Time: JAN 22 2014 6:56				

479 for LHA/PE

4 5 lbs nice 9/13  
per pt the crown fell off for her left  
molar, left with hip conts.  
Plans to quit tobacco now  
down to last pack. Pres  
Nicotine patch or any meds.  
Td 710gm

A LHA/PE  
thinks  
IGT.  
↓ Cath.  
Wt 9 calvec 1/5.

11/05/13.  
Hpt 6'0".  
TSH 1.48  
hpt 189/51/47/  
CBC normal  
Non HDL 142  
A.

137/102/14  
4.1/28/0.74  
Cath 8.7L  
hpt 189/51/47/  
b13

PATIENT DATA - Imprint or Print Legibly	
Name:	
MR:	MID-VALLEY COMP. - CENTER PATIENT IDENTIFICATION 233 35 41 DOB: 12/17/1966
Dat:	GOLD, KATHLEEN ER PREF. LANG: ENGLISH SEX: F
War:	
Req. Loc. Code:	



T-MV02

FILE IN MEDICAL RECORD

PAGE 1 OF 2

**ADULT VISIT RECORD**

MV02 (7-13)

add excel I don't know if  
to call 1800 no but for it  
Cowellip.

# NURSING NOTES

## Labs

☐ Specimen obtained and sent for:

☐ Pap ☐ Other: \_\_\_\_\_

☐ Lab slips given with instructions # ( / )

Order #'s L432216

Order #'s \_\_\_\_\_

Order #'s \_\_\_\_\_

## Radiology

☐ X-ray slips given with instructions

Order #'s \_\_\_\_\_

## Immunizations

☐ No contraindications present

Immunizations given:

☐ TDAP ☐ dT ☐ Pneumovax

☐ PPD ☐ Flu ☐ Zoster vaccine

☐ Other \_\_\_\_\_

## TB Testing

☐ PPD placed left forearm. Return 48-72 hrs

## Other Instructions

☒ MD orders reinforced

☒ Follow-up instructions given

☐ Medications ( # ) Or Rx ( # )

given with instructions

1-800-600-6000

Referrals (explained, submitted)

Optometry Screening:

☐ Retinal camera ☐ Ophthalmology

☐ Social Work ☐ Health Ed ☐ Care Manager

☐ Service Coordinator

## Patient Education

Topic: Counsel Pamphlet Video

Low salt diet ☐

Low K+ diet ☐

TB ☐

Pain Mgt. ☐

Dyslipidemia ☐

Diabetic diet ☐

Exercise ☐

High fiber ☐

ECP ☐

Tobacco cessation ☐

Staying Healthy Ed. ☐

Self-Mgt/Smart goals ☐

GERD ☐

Other: ☐

Patient given instructions/education by nurse / CMA and demonstrated understanding by:

☐ verbalization of understanding

☐ repeating information

☐ demonstrating activity

Education in Clinic: N = Nurse to give handout / education P = Discussed by provider

N	P	N	P	N	P	N	P
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Orders: <input type="checkbox"/> Today <input checked="" type="checkbox"/> One week before next visit <input type="checkbox"/> In _____ weeks	<input type="checkbox"/> Fasting
<input type="checkbox"/> Pap	<input type="checkbox"/> CBC w/o diff <input checked="" type="checkbox"/> HgbA1C
<input type="checkbox"/> FOBT	<input type="checkbox"/> CBC w/ diff <input type="checkbox"/> Gluc. (poc)
<input type="checkbox"/> EKG	<input type="checkbox"/> Hgb (poc)
<input type="checkbox"/> Pulse ox	<input type="checkbox"/> TSH
<input type="checkbox"/> Chlamydia screen (age 15-24)	<input type="checkbox"/> B12 / folate
<input type="checkbox"/> Other: _____	<input type="checkbox"/> PFT

Radiology (indicate reason): ☐ CXR PA&LAT ☐ CXR one view ☐ screening mammo ☐ BE ☐ UGI

☐ Other: \_\_\_\_\_ Indication: \_\_\_\_\_

Immunizations: ☒ TDAP 0.5cc IM ☐ Pneumovax 0.5cc IM ☐ dT 0.5cc IM

☐ PPD 0.1cc ID

☒ Flu vaccine 0.5cc IM

☐ Other: \_\_\_\_\_

☐ Zoster vaccine 0.5cc SQ

Referral(s) to: ☐ Health Educator ☐ Care Manager ☐ DM ophthalmology ☐ Podiatry (MV)

☐ Social Work

☐ Service Coordinator

☐ Other: \_\_\_\_\_

☐ Nutrition counseling

☐ DM eye screening

Women's for: ☐ Screening only ☐ Other: \_\_\_\_\_

Follow-up: ☐ With PCP in / ☐ for IHA in: \_\_\_\_\_

Provider Name: M. C. H. M. Time: 8:00 AM

Provider Sign: MC H. M. MD / NP / PA / Student

Attending Name: \_\_\_\_\_

Attending Signature: \_\_\_\_\_

Nurse / CMA Name: L. P. M. M.

Nurse / CMA Signature: LP M. M.

Date / Time: 1/22/14 8:07 AM

Addendum: \_\_\_\_\_

Signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_

**AMBULATORY CARE NETWORK**  
**MID-VALLEY CHC, SAN FERNANDO AND GLENDALE HEALTH CENTERS, VAUGHN SBC**

Abnormal NO MARK=NOT EXAMINED  
 Normal or No significant findings.)

**GENERAL APPEARANCE**  
 Appearance ☒ ☐  
 Adenopathy ☒ ☐

**EAD**  
 Scalp ☒ ☐  
 Ears - External ☒ ☐  
 Internal ☒ ☐  
 Eyes-General ☒ ☐  
 Fundoscopic ☒ ☐  
 Oral cavity ☒ ☐

**ECK**  
 Thyroid ☐ ☐

**HORAX, AND**  
 Chest Wall ☐ ☐

**EART**  
 PMI ☐ ☐  
 Rate / Rhythm ☐ ☐  
 Murmur ☐ ☐  
 Gallop ☐ ☐  
 JVP ☐ ☐

**UNGS**  
 Auscultation ☐ ☐  
 Percussion ☐ ☐  
 Excursions ☐ ☐

**REASTS**  
 Skin changes ☐ ☐  
 Nipple / Areola ☐ ☐  
 Axilla ☐ ☐  
 Masses ☐ ☐

**BDOMEN**  
 Bowel Sounds ☐ ☐  
 Liver/Spleen Size ☐ ☐  
 Masses ☐ ☐  
 Abdomen Tenderness ☐ ☐  
 CVA tenderness ☐ ☐

**MUSCULOSKELETAL**  
 Extremities ☒ ☐  
 Clubbing ☒ ☐  
 Cyanosis ☒ ☐  
 Edema ☒ ☐  
 Joints ☒ ☐  
 Back ☒ ☐

**DOT EXAM** ☐ ☐

**ASCULAR SYSTEM**  
 Carotids ☐ ☐  
 Abdominal Aorta ☐ ☐  
 Femorals ☐ ☐  
 Posterior tibials ☐ ☐

**ENITALIA**  
 Male  
 Penis ☐ ☐  
 Testicles & epididymis ☐ ☐  
 Female  
 External Genitalia ☐ ☐  
 Vagina ☐ ☐  
 Cervix ☐ ☐  
 Uterus ☐ ☐  
 Adnexa ☐ ☐

**NORECTAL**  
 External Appearance ☐ ☐  
 Digital Exam ☐ ☐  
 Prostate Gland ☐ ☐

**EUROLOGICAL**  
 Alertness & orientation ☒ ☐  
 Cranial nerves (II-XII) ☒ ☐  
 Motor ☒ ☐  
 Sensory ☒ ☐  
 DTR ☒ ☐  
 Cerebellar ☒ ☐  
 Memory ☒ ☐  
 Speech ☒ ☐

(see over for Assessment, Plan, Orders)

**Nursing Intake**

BP	Temp	HR	RR	*Pain Level	Pain Goal	Pain Tool	Pain Location
114/64/98	98	74	16	5/10	0/10	0-10 Faces	<input type="checkbox"/> Back <input checked="" type="checkbox"/> Head Other: <input checked="" type="checkbox"/>

WEIGHT: 183 HEIGHT: 5'2 BMI: 33  
 Currently Smoking: ☐ Yes ☒ No

LMP: 01/08 Allergies:

Good allergies  
 NKOR

Reason for visit: (Circle Applicable):	New / IHA	Return	Same Day	Interpreter
<b>Annual Fall Assessment:</b>				
1. Has there been an unexpected fall in the preceding 3 months?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			<input type="checkbox"/> Provided
2. Does patient have an unstable gait (with or without assistance / assistive device)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			<input type="checkbox"/> Declined
3. Does patient have any changes in vision, strength or sensation/loss of feeling?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			<input type="checkbox"/> N/A
4. Is patient on meds that may lead to fall risk (e.g. narcotics or cardiac-related drugs)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
If any of the questions 1 to 4 is marked as "yes" - Fall precaution taken and education provided <input type="checkbox"/> Yes				
Signature: Vilma Toscano, NA	NA/CMA/LVN/RN	Date/Time: 8:42	SEP 23 2013	

46♀ problem with

Need a letter states that she can not sign  
 the waiver for the pesticide spray in her  
 home.

Has small claim lawsuit over landlord  
 her room/apartment is filled with cockroaches  
 and mole. court has order the cleanup  
 of that. pesticide company gives her a paper  
 to sign the waiver in case of any unwanted  
 reactions. She wants to find out whether  
 she is allergic or not.

allergy - white egg/syr  
 PMHx - cellulitis  
 neck pain, headache due to stress x  
 mild stuffy nose (+)

(A) cervical strain  
 Tension headache

**PATIENT DATA - Imprint or Print Legibly**

Name:

MRUN:

Date of Birth:

Ward or Clinic:

Req. Loc. Code:

MID-VALLEY COMP. - CENTER PT. IDENTIFICATION  
 233 35 41 DOB: 12/17/1966  
**GOLD, KATHLEEN PHWR**  
 PREF. LANG. ENGLISH SEX: F

**ADULT VISIT RECORD**



T-MV02

FILE IN MEDICAL RECORD

PAGE 1 OF 2

MV02 (7-13)

~~toxicology~~

pari

MV02 (7-13)

Date: 5-13-14 Time: 10:35	<input type="checkbox"/> IP <input checked="" type="checkbox"/> OP	<input type="checkbox"/> Unable to assess PAIN/VS due to patient disability
Visit Type: <input type="checkbox"/> New <input checked="" type="checkbox"/> Established <input type="checkbox"/> Recall <input type="checkbox"/> Emergent <input type="checkbox"/> Consult	Pain Score: 0 1 2 3 4 5 6 7 8 9 10 (each visit)	
Procedure: ext #19 root tips	<input type="checkbox"/> Pain 4 or More: <input type="checkbox"/> Tolerated <input type="checkbox"/> Treatment see below	<input type="checkbox"/> Medication Rx <input type="checkbox"/> Referred to
Allergies: NKDA	B/P: 90/55 Pulse: 73 Resp:	
Dental Diagnosis(es): Root tip #19	Temp:	Weight:
Medical Diagnosis(es): Healthy	AHA Proph: <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Taken:	
Current Medications: <input type="checkbox"/> Patient takes no medications	X-Rays today: <input checked="" type="checkbox"/> None <input type="checkbox"/> FMX <input type="checkbox"/> Bitewings (2)(4)	
<input type="checkbox"/> No medication changes since last visit	<input type="checkbox"/> Panorex <input type="checkbox"/> Periapical(s) Location:	
<input checked="" type="checkbox"/> Current medication list is in medical record: verify/check every visit	<input type="checkbox"/> Other:	
<input type="checkbox"/> Patient has or was given copy of medication list: verify/check every visit	Informed Consent Signed: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> N/A	
Time Out Site Verification: <input checked="" type="checkbox"/> completed prior to beginning procedure	<input type="checkbox"/> N/A	
Prescription(s) written today: N/A		

Procedure Note: See Clinical Workstation

Follow-up:	Education~Patient/Family verbalized understanding of the following issues:			
Post-procedure instructions given to patient	<input checked="" type="checkbox"/> Treatment provided today <input checked="" type="checkbox"/> How/when to contact clinic/dentist			
Special follow-up instructions:	<input type="checkbox"/> Individual oral hygiene instruction, adapted techniques & equipment			
	<input checked="" type="checkbox"/> Tobacco cessation: Use tobacco? Y N if yes, Willing to Quit? Y N			
	if yes, Info Given? Y N <input type="checkbox"/> Referral to 1-800-NO BUTTS			
Make return visit in _____ weeks <input type="checkbox"/> or months <input type="checkbox"/>				
Provider: [Signature]	Print Last Name: LOPEZ	Provider #: 528922	Date: 5/13/14	Time:
Attending: [Signature]	Print Last Name:	Provider #:	Date:	Time:

PATIENT DATA - Imprint or Print Legibly	
Name:	
MID-VALLEY COMP. - CENTER PATIENT IDENTIFICATION	
MRUN: 233 35 41	DOB: 12/17/1966
GOLD, KATHLEEN PHWR	
Date of E	PREF. LANG: ENGLISH SEX: F
Ward or C...	
Reg. Loc. Code:	

Dental Center Progre.

OLIVE VIEW MEDICAL CENTER  
Printed: Tue May 13, 2014 11:23 AM

Name=GOLD, KATHLEEN

DOB=12/17/1966

Age=47

Sex=F

Demand Copy

MRUN=233-35-41

Acct #=7070879

## FINAL REPORT

## AMB CARE DENTAL EXTRACTION PROC NOTE

=====

Date of procedure: 5/13/14

Patient was offered a copy of the Dental Materials and Facts Sheet.  
Smoking Cessation information offered if the patient smokes.

S:

Pt. presents for extraction on tooth #19.

O:

MH: reviewed.

MH: Healthy.

A:

Patient has severe caries on remaining root tip #19. Tooth has a poor prognosis. Best treatment is extraction.

P:

Went over the risks, benefits, and alternatives of an extraction for tooth #19 with the patient. Gave the patient treatment options of observe or extract. Patient opted to extract tooth #19. Patient signed the consent form. Answered any questions the patient had. Gave topical anesthetic. Gave 1.5 carpules 1:100,000 2% lidocaine w/epi. Time out procedure completed. Showed the patient the tooth to be extracted with the patient mirror. Used the periosteal, straight elevator, and 151 forceps. Simple extraction. Irrigated extraction site with chlorhexidine oral rinse in a monojet. Placed pressure with gauze. Gave verbal and written post-op instructions. Answered all of the patient's questions. Patient left content.

Behavior: Good. Positive.

NV: No appointment made at this time.

Used Interpreter - Name: N/A

Used HCN - Interpreter ID #: N/A

Interpretation language: N/A

Dictated By=LOPEZ, ABREY K. (DDS)

D/T=05/13/2014 1123

Text Status=FINAL

Elec Signed By= (Electronic Signature)

D/T=05/13/2014 1123


LOPEZ, ABREY K. (DDS)

Transcribed By=LOPEZ, ABREY K.

D/T=05/13/2014 1123

Printed By: Abrey K. Lopez, DDS

Printed: 05/13/2014 11:23 AM

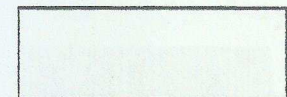
 528922 5/13/14  
Confidential Patient Information  
NOT A CHART COPY

Page 1

Date: 4-1-14 Time: 10:10 ☐ IP ☒ OP ☐ Unable to assess PAIN/VS due to patient disability  
 Visit Type: ☒ New ☐ Established ☐ Recall ☐ Emergent ☐ Consult Pain Score: 0 1 2 3 4 5 6 7 8 9 10 (each visit)  
 Procedure: Emergency exam #19 ☐ Pain 4 or More: ☐ Tolerated ☐ Treatment see below ☐ Medication Rx ☐ Referred to  
 Allergies: Soy, Gluten B/P: 95/59 Pulse: 71 Resp:  
 Dental Diagnosis(es): Root tips #19 Temp: Weight:  
 Medical Diagnosis(es): Healthy AHA Proph: ☐ N/A ☐ Taken:  
 Current Medications: ☐ Patient takes no medications X-Rays today: ☐ None ☐ FMX ☐ Bitewings (2)(4)  
☐ No medication changes since last visit ☐ Panorex ☒ Periapical(s) Location: #19  
☒ Current medication list is in medical record: verify/check every visit ☐ Other: (1)  
☒ Patient has or was given copy of medication list: verify/check every visit Informed Consent Signed: ☐ Yes ☒ N/A  
 Home Out Site Verification: ☐ completed prior to beginning procedure ☒ N/A  
 Prescription(s) written today: N/A

Procedure Note: see Clinical Workstation

Follow-up: Post-procedure instructions given to patient  
 Special follow-up instructions: \_\_\_\_\_  
 Make return visit in \_\_\_\_\_ weeks | | or months | |  
 Provider: [Signature] GOPEZ 528922 4/1/14  
 Signature Print Last Name Provider # Date Time  
 Attending: \_\_\_\_\_  
 Signature Print Last Name Provider # Date Time



binex T-OV2268 and T-OV2269

PATIENT DATA - Imprint or Print Legibly  
 Name: \_\_\_\_\_  
 MRUN: \_\_\_\_\_  
 Date of: \_\_\_\_\_  
 Ward or: \_\_\_\_\_  
 Rec. Loc. Code: \_\_\_\_\_  
 MID-VALLEY COMP. - CENTER PATIENT IDENTIFICATION  
 233 35 41 DOB: 12/17/1966  
 GOLD, KATHLEEN ER  
 PREF. LANG: ENGLISH SEX: F

Dental Center Progre.

TO BE COMPLETED BY PARENT OR GUARDIAN (if patient is a minor):

RESPONDAN LAS SIGUIENTES PREGUNTAS LOS PADRES O GUARDIANES (si el paciente es menor de edad):

Please explain any "yes" answers questions 3-11

1. What age is the patient?  
¿Que edad tiene el paciente? 43 yrs años        mos meses
2. Is patient now in good health?  
¿Esta el paciente ahora en buena salud? si ☒ yes ☐ no
3. Has patient been sick or under the care of a physician within the past two years?  
¿Ha estado el paciente enfermo o bajo el cuidado de un médico durante los ultimos dos años? si ☐ yes ☒ no
4. Has patient had serious illness or an operation?  
¿Ha tenido el paciente alguna enfermedad grave o alguna operacion? si ☐ yes ☒ no
5. Has patient had excessive bleeding after a cut, injury, or tooth extraction?  
¿Ha sangrado demasiado el paciente despues de una cortada, o un golpe o una extraccion de diente? si ☐ yes ☒ no
6. Is patient subject to any nervous disorder, fainting, or dizziness?  
¿Está el paciente sujeto a alguna enfermedad nerviosa, desmayos o mareos? si ☐ yes ☒ no
7. Is patient taking any drug or medication?  
¿Está el paciente tomado alguna medicina o droga? si ☐ yes ☒ no
8. Is patient sensitive or allergic to penicillin, novacaine, or other drugs?  
¿Es el paciente sensitivo o alergico a la penicilina, anestesia o otras drogas? si ☐ yes ☒ no
9. Has patient a history of heart trouble (including rheumatic fever), high blood pressure, diabetes, asthma, tuberculosis, kidney or liver involvement, or any other constitutional disorder? (If answer is yes, underline condition.)  
¿Tiene el paciente una historia de enfermedad del corazón (incluyendo fiebre reumática), alta presion, diabetis, asma, tuberculosis, desorden en los riñones o higado? (Si la respuesta es si, describalo en las lineas abajo.) si ☐ yes ☒ no
10. Has patient had unfavorable reaction from previous dental treatment?  
¿Ha tenido el paciente alguna reacción desfavorable a algun tratamiento dental anterior? si ☐ yes ☒ no
11. Has patient had a history of hepatitis or venereal disease?  
¿Ha tenido el paciente alguna historia de hepatitis, o enfermedad venerla? si ☐ yes ☒ no
12. Is the patient pregnant? (If female) ☐ Uncertain  
¿Esta el paciente embarazada? (Si es mujer) ☐ Insegura si ☐ yes ☒ no
13. Details concerning any serious illness:  
Detalles concernientes a alguna enfermedad grave:

SIGNATURE:

IRMA:

DATE:

FECHA:

RELATIONSHIP:

RELACION:

PATIENT NAME:

NOMBRE DEL PACIENTE:

PATIENT ADDRESS:

DIRECCION DEL PACIENTE:

PATIENT PHONE NO.:

NUMERO DEL PACIENTE:

REVIEWING DENTIST'S SIGNATURE

DATE

PATIENT DATA - Imprint or Print Legibly

Name:

MRUN:

Date of B

Ward or Ch.

Req. Loc. Code:

MID-VALLEY COMP. - CENTER PATIENT IDENTIFICATIO

233 35 41

DOB: 12/17/1966

GOLD, KATHLEEN ER

PREF. LANG: ENGLISH SEX: F



T-OV1072

FILE IN MEDICAL HISTORY

PAGE 1 OF 1

DENTAL MEDICAL HISTORY

OV1072 (6-07)



OLIVE VIEW MEDICAL CENTER  
Printed: Tue Apr 1, 2014 11:59 AM

Name=GOLD, KATHLEEN

DOB=12/17/1966

Age=47

Sex=F

Demand Copy

MRUN=233-35-41

Acct #=7070879

## FINAL REPORT

## AMB CARE DENTAL EMERGENCY EXAM CLIN NOTE

=====

Date of clinic visit: 4/1/14

Patient was offered a copy of the Dental Materials and Facts Sheet.  
Smoking Cessation information offered if the patient smokes.

S:

Pt. presents for emergency exam on tooth #19. Pt referred to USC School of Dentistry for an implant consultation.

O:

MH: reviewed. MH: Healthy.

A: Pt has root tips remaining on #19. Pt requires an ext and is interested in replacement. No abscess or pain present at this time.

P:

Took 1 periapical film. Oral and radiographic exams revealed pt has carious root tips remaining on #19. Let the patient know the treatment options are to observe or extract. Pt stated she is interested in replacing the space if the tooth is extracted. Pt is interested in an implant consultation. Let the patient know she would benefit from a comprehensive exam and treatment at USC School of Dentistry and she could see if she would be a good candidate for an implant. Pt most likely would need a bone graft prior to an implant. Pt would like a referral. Let the patient know if sh has any discomfort or an abscess forms on #19, she needs to have #19 extracted. An infection can form and spread and become life threatening if the tooth is not extracted. The patient understood. Answered all of the patient's questions and filled out a referral form for the patient.

Behavior: Good. Positive.

Next visit: No appt made.

Used Interpreter - Name: N/A

Used HCN - Interpreter ID #: N/A

Interpretation language: N/A

=====

Dictated By=LOPEZ, ABREY K. (DDS)

D/T=04/01/2014 1159

Text Status=FINAL

Elec Signed By= (Electronic Signature)

D/T=04/01/2014 1159

LOPEZ, ABREY K. (DDS)

Transcribed By=LOPEZ, ABREY K.

D/T=04/01/2014 1159

Printed By: Abrey K. Lopez, MD  
Printed: 04/01/2014 11:58 AM

Confidential Patient Information  
NOT A CHART COPY

Page 1

Patient Acknowledgement of  
Receipt of Dental Materials Fact Sheet

I, Kathy Goud

Patient's Name (Parent or Guardian if patient is a minor)

acknowledge I have received from MidValley Dental Clinic a  
copy of the Dental Materials Fact Sheet Dated October 2001.

Kathy Goud

Patient's (or Parent's) Signature

4/1/2014

Date

MID-VALLEY COMP. - CENTER PATIENT IDENTIFICATION  
233 35 41 DOB: 12/17/1966  
GOLD, KATHLEEN ER  
PREF. LANG: ENGLISH SEX: F



**Nursing Intake: Gravida** 0 **Para** 0 **(TSAB)** 0  
Reason for visit: new m/c note Date: 12/26/13 Time: 10:20 W  
LMP: 2002 Age: 47 BP: 105/50 P 73 R 16 Pain: 0/W Goal: 0/W  
Birth Control Method: menopausal Weight: 187 lbs  
Signature: [Signature] NA/LVN/RN Print Name: [Signature] NA/LVN/RN  
Since your last visit, have any of the following occurred to you? (Please complete the appropriate section according to patient's method)

**All methods:**

- N/A Y N  
☐ ☐ ☒ Failed to use method  
☐ ☐ ☒ New sex partner  
☐ ☐ ☒ Hospitalization (since last visit)  
☐ ☐ ☒ New medication or drug  
☐ ☐ ☒ Abnormal vaginal discharge or itch  
☐ ☐ ☒ Do you need Emergency Contraception?

**Condom/Diaphragm:** ☒ N/A

- Y N  
☐ ☐ Break or slip  
☐ ☐ Rash or discomfort

**For women with an IUD:** ☒ N/A

- Y N  
☐ ☐ String missing or partner feels string  
☐ ☐ Severe abdominal pain

Signature: [Signature]  
Print name and title

**Hormonal Method:** (HRT/Depo/Patch/OC) ☒ N/A

- Y N  
☐ ☐ Bleeding between periods  
☐ ☐ Mood changes/sadness  
☐ ☐ Chest pain  
☐ ☐ Severe abdominal pain  
☐ ☐ Severe calf or thigh pain  
☐ ☐ Severe headache  
☐ ☐ Visual changes  
☐ ☐ Have you missed any pills / patches / shots?

**Natural Family Planning:** ☒ N/A

- Y N  
☐ ☐ Are your periods ever more than 35 or less than 25 days apart?  
☐ ☐ Have you had sex during unsafe days in your cycle?

**Currently seek pregnancy:** ☒ N/A

- Y N  
☐ ☐ Are your periods ever more than 35 or less than 25 days apart?

**Additional subjective data:**

patient is here requesting a letter to  
confirm that her last period was in 2002 -  
for court as a Court evidence.

**Physical Exam:** (N=Normal; A=Abnormal, No mark=(Not Examined))

- N A  
☐ ☐ Breasts  
☐ ☐ Abdomen  
☐ ☐ Vulva  
☐ ☐ Vagina  
☐ ☐ Cervix  
☐ ☐ Uterus  
☐ ☐ Adnexa  
☐ ☐ Other

**Lab Results:**

11/05/13 Mammogram NG  
2004 Pap outside clinic  
FST - 46

**PATIENT DATA - Imprint or Print Legibly**

Name:

MRUN:

Date of E

Ward or C

Req. Loc. Code:

MID-VALLEY COMP. - CENTER PATIENT IDENTIFICATION  
233 35 41 DOB: 12/17/1966  
GOLD, KATHLEEN ER  
PREF. LANG: ENGLISH SEX: F



T-OV2119

FILE IN MEDICAL RECORD

PAGE 1 OF 2

OV2119 (6-07)

WOMEN'S REVISIT RECORD

Assessment:

Requester a letter  
For civil court  
to inform that her  
LH was 7002.

**Plan:**

- ☐ Pregnancy Test
- ☐ Pap smear
- ☐ GC PCR w/ amplif.
- ☐ CT PCR w/ amplif.
- ☐ Urine Dip
- ☐ Depo/150mg IM x \_\_\_\_\_
- ☐ Pill refill
- ☐ Plan B
- ☐ Foam / Condom # \_\_\_\_\_
- ☐ Other: \_\_\_\_\_

**Patient Education:** (N=Ordered for Nurse; P=Done by Provider)

- N P
- ☐ ☐ Discussion of Lab results
  - ☐ ☐ Discussion of Radiology results
  - ☐ ☒ Method related counseling
  - ☐ ☐ STI protection
  - ☐ ☐ Other: \_\_\_\_\_

As there is no  
objective evidence  
her request is  
denied.

patient will get  
such a letter from  
her former provider  
who had followed  
her for more than  
10 years

**Nursing Disposition**

**Labs:**

**Radiology:**

- ☐ Radiology slips given with instructions
- ☐ Order # \_\_\_\_\_

**Patient Education:**

- ☐ Medication (#) \_\_\_\_\_
- ☐ Method related counseling done
- ☐ Education completed as ordered
- ☐ Other: \_\_\_\_\_

**Patient Expressed Understanding By:**

- ☐ Repeating information
- ☐ Repeat demonstration
- ☐ Other: \_\_\_\_\_

Signature RN/LVN

Print Name

12/26/13  
Date

1010  
Time

**RTC:**

As needed.

Provider  
Signature: \_\_\_\_\_

Date/Time: 12/26/13

Print Name: \_\_\_\_\_

1010

Attending MD: \_\_\_\_\_

Date/Time: \_\_\_\_\_

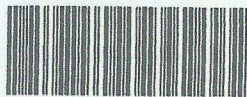
## WOMEN'S Health Assessment Record

(N=Normal or No Significant findings A=Abnormal, if abnormal please comment. NO MARK=NOT EXAMINED)

<b>Physical Exam:</b>	N <input checked="" type="checkbox"/> A <input type="checkbox"/>	History/Exam/Abnormal Findings:	<b>Nursing Intake:</b>
General Appearance	<input type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> History reviewed	<b>Patient Type</b> T 97.6
Thyroid:	<input checked="" type="checkbox"/> <input type="checkbox"/>	46 y. h/w for annual f exam	New Patient <input type="checkbox"/>
<b>Breast:</b>		OB/gyne h/o TABX 2	Annual <input checked="" type="checkbox"/>
Skin Changes	<input checked="" type="checkbox"/> <input type="checkbox"/>		Family Planning <input type="checkbox"/>
Masses	<input checked="" type="checkbox"/> <input type="checkbox"/>		Postpartum <input type="checkbox"/>
Nipple Discharge	<input checked="" type="checkbox"/> <input type="checkbox"/>		Postabortion <input type="checkbox"/>
Lymph Nodes	<input checked="" type="checkbox"/> <input type="checkbox"/>		Age: 46
<b>Heart:</b>			G 2 P 0 (S) TAB 2
Rate/Rhythm	<input type="checkbox"/> <input type="checkbox"/>	FMP Fm h/o breast CA cranial CA 76	<b>Allergies:</b>
Murmur	<input type="checkbox"/> <input type="checkbox"/>	STD's h/o - E	Gluken/SN/egg white
<b>Lungs:</b>		pap - last pap @ age 38	BP: 95/55 P72
Auscultation	<input type="checkbox"/> <input type="checkbox"/>	mamm - E	Weight: 185
<b>Abdomen:</b>		sexual activity - abstinence > 10 yrs	Height: 5'2
Liver/Spleen	<input type="checkbox"/> <input type="checkbox"/>	social & ⊕ smoking	<b>Pain Level:</b>
Masses	<input checked="" type="checkbox"/> <input type="checkbox"/>	urine incont - E	0/10
CVA Tenderness	<input checked="" type="checkbox"/> <input type="checkbox"/>	depression - E	<b>Pain Goal:</b>
<b>Genitalia:</b>			0/10
External Appearance	<input checked="" type="checkbox"/> <input type="checkbox"/>		<b>LMP:</b> 2002
Urethra	<input checked="" type="checkbox"/> <input type="checkbox"/>		<b>Current Birth Control Method:</b>
Barthol's/Skene's	<input checked="" type="checkbox"/> <input type="checkbox"/>		N/A
Vagina	<input checked="" type="checkbox"/> <input type="checkbox"/>		<b>Date of last pill</b>
Cervix	<input checked="" type="checkbox"/> <input type="checkbox"/>		<b>Date of last DMPA</b>
Adnexa	<input checked="" type="checkbox"/> <input type="checkbox"/>		<b>Date of last IUD insertion</b>
<b>Uterus:</b>			
Size	<input type="checkbox"/> <input type="checkbox"/>		
Contour	<input type="checkbox"/> <input type="checkbox"/>		
Mobility	<input type="checkbox"/> <input type="checkbox"/>		
<b>Rectal:</b>			
External Appearance	<input checked="" type="checkbox"/> <input type="checkbox"/>		
Digital Exam	<input checked="" type="checkbox"/> <input type="checkbox"/>		
<b>Extremities:</b>			
Edema	<input checked="" type="checkbox"/> <input type="checkbox"/>		
Pulses	<input type="checkbox"/> <input type="checkbox"/>		
<b>Skin:</b>	<input type="checkbox"/> <input type="checkbox"/>		
<b>Other:</b>	<input type="checkbox"/> <input type="checkbox"/>		

A/P well & exam  
 (1) @ PSE - NL  
 pelvic exam - limited  
 20 fight  
 introitus  
 (2) Postmenopausal  
 EPMH

RN/LVN/NA  
 Signature  
 Print Name  
 NOV 04 2013  
 Date  
 1825  
 Time



T-OV2109

FILE IN MEDICAL RECORD

PATIENT DATA - Imprint or Print Legibly	
Name:	MID-VALLEY COMP. - CENTER PATIENT IDENTIFICATION
MRUN.	233 35 41 DOB: 12/17/1966
Date of	GOLD, KATHLEEN ER
Ward or Clinic:	PREF. LANG: ENGLISH SEX: F
Req. Loc. Code:	

WOMEN'S HEALTH ASSESSMENT RECORD

PAGE 1 OF 2

OV2109 (8-06)

Hepatitis B 1cc IM x 3  
Birth Control Method: N/A

(3) cont. - 1st w/ PMP - labs.  
Smoking - 1800 No BvHs

**NURSING DISPOSITION:**

**LABS:**

- ☐ PAP L31992  
☐ Other: \_\_\_\_\_

- ☐ Lab order (#) \_\_\_\_\_

- ☐ Provider orders reinforced

**RADIOLOGY:** X627538

- ☒ Radiology slips given with instructions  
☐ Order # \_\_\_\_\_

**PATIENT EDUCATION / INSTRUCTIONS**

- ☐ Medication (#) \_\_\_\_\_ or Rx (#) \_\_\_\_\_  
☐ Foams/Condoms (#) \_\_\_\_\_  
☐ Provider orders reinforced  
☐ Method related counseling done?  
    ☐ Yes   ☐ No  
☐ Other \_\_\_\_\_

**LABS/TEST:**

- ☐ PAP  
☐ GC DNA w/ amplification  
☐ CT DNA w/ amplification  
☐ RPR  
☐ HIV, combined, w/ pre & post test counseling  
☒ Other 1800

- ☐ HSV Culture  
☐ Pregnancy Test  
☐ Urine Dip  
☐ Hg/Hct (IUD)  
☐ FBS (OCP/Depo)  
☐ Cholesterol (OCP)

**2°/Concurrent Dx:**

- ☐ Wet Mount  
☐ U/A  
☐ Urine C & S  
☐ CBC/ESR

**Adult Health Assessment**

- ☐ Stool Occult Blood x 3  
☐ Fasting lipid panel

**RADIOLOGY:**

- ☐ Pelvic Ultrasound  
☒ Screening Mammogram  
☐ Other \_\_\_\_\_

NW 5, 2013 @ 94%

**PATIENT EDUCATION: N=ordered for Nurse; P=done by provider**

- N P**  
☒ ☒ Physical Exercise/Nutrition  
☒ ☒ Breast Self Exam  
☒ ☒ Domestic Violence  
☒ ☒ Pain Management  
☒ ☒ Cancer Prevention  
☐ ☐ Discussion of lab results  
☐ ☐ Discussion of radiology results

- N P**  
☒ ☒ Calcium supplementation  
☒ ☒ Smoking Cessation  
☐ ☐ HIV/STI Prevention  
☐ ☐ Birth Control Method: \_\_\_\_\_  
☐ ☐ Adolescent Counseling per protocol (≤17 yrs)  
☐ ☐ Other \_\_\_\_\_

- N P**  
☐ ☐ EC/Plan B

**REFERRALS:**

- ☐ Nutritionist   ☐ Health Educator   ☐ HIV Referral List   ☐ Community Partners List  
☐ Social Worker   ☐ Specialist

Return to clinic: pm (timeframe)

**RN/LVN/NA**

[Signature]  
Signature

NOV 04 2013  
Date

Time

Provider Signature: [Signature]  
Print Name: \_\_\_\_\_  
Attending MD Signature: \_\_\_\_\_

Date: NOV 04 2013  
Time: \_\_\_\_\_  
Date: 7:00  
Time: \_\_\_\_\_

MR# \_\_\_\_\_  
DOB \_\_\_\_\_

OVMC LIVE  
RESULTS BY RESULT VIEW  
Printed Tue Oct 27, 2015 8:47 AM by MGP,MVMR

Name:GOLD, KATHLEEN  
35-41  
Loc:MVHC  
Acc#:7070879

Sex:F  
Adm:09/19/13

DOB:12/17/1966  
Att:

MRUN:233-

COMPREHENSIVE VIEW Result View for 09/23/13 0001 - 10/27/15 0847 (Only the Results Shown on the Grid):

Test	Normal Range	11/05/13 1008 OP	11/05/13 0915
LABORATORY			
BLOOD BANK			
BLOOD GAS			
Chemistry			
NA	(136-144)	137	
K	(3.6-5.1)	4.1	
CL	(97-108)	102	
BICARBONATE	(22-32)	28	
ANION GAP	(5-14)	@ 7	
BUN	(8-20)	14	
CREAT	(0.60-1.30)	0.74	
eGFR		@ 84	
GLU	(65-139)	@ 95	
CA	(8.9-10.3)	L 8.7	
AST	(15-41)	18	
ALT	(14-54)	15	
ALK PHOS	(38-126)	87	
T BILI	(0.1-1.2)	0.7	
D BILI	(0.1-0.4)	0.2	
T PROTEIN	(6.5-8.1)	L 6.3	
ALBUMIN	(3.5-4.8)	3.7	
CHOL		189	
TRIG		51	
HDL	(40-60)	@ 47	
LDL		@ 129	
VLDL		10	
CHOLESTEROL/HDL		@ 4.0	
NON-HDL CHOLEST		@H 142	
PATIENT FASTING		YES	
TSH	(0.550-4.780)	1.480	
COAGULATION			
POC/ANTICOAG			
CYTOLOGY			
FLOW CYTO			
HEMATOLOGY			
WBC COUNT	(3.8-10.9)	9.4	
RBC COUNT	(3.66-5.34)	4.46	
Hgb	(11.2-16.0)	13.4	
HCT	(33.3-47.1)	40.9	
MCV	(77.5-99.5)	91.8	
MCH	(26.3-34.3)	30.0	
MCHC	(32.7-35.5)	32.7	

OVMC LIVE  
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35-41  
Loc:MVHC  
Acc#:7070879

Sex:F  
Adm:09/19/13

DOB:12/17/1966  
Att:

MRUN:233-

Test	Normal Range	11/05/13 1008 OP	11/05/13 0915
RDW	(11.2-14.8)	14.4	
PLT COUNT	(141-401)	351	
MPV	(7.0-10.9)	8.0	
Microbiology			
PATHNET LABS			
POCT			
REF LABS			
FSH,SERUM		@ RES	
SEROLOGY			
HGB A1C		@H RES	
SURG PATH			
URINALYSIS			
Env Service			
CARDIOLOGY			
Neurology			
Nsg. Orders			
Prenatal			
Plmry Fnctn			
TFU			
Radiology			
CT			
DIAG			
mri			
Nuc Med			
Rad/ER			
US			
RAD Mammo			
Call X-4096			
MAMMOGRAM SCREE			
sched diag			
sp			

SIGNED

OVMC LIVE  
RESULTS BY RESULT VIEW  
Printed Tue Oct 27, 2015 8:47 AM by MGP,MVMR

Name:GOLD, KATHLEEN  
35-41  
Loc:MVHC  
Acc#:7070879

Sex:F  
Adm:09/19/13

DOB:12/17/1966  
Att:

MRUN:233-

BP (Collected 11/05/13 1008, L143641-1):  
ANION GAP

Comment: ANION GAP = NA - (CL + HCO3)

eGFR

Comment: If patient is African American,  
multiply the result by 1.21  
  
Chronic Kidney Disease (CKD) Stages  
based on estimated GFR:

GFR ml/min/1.73m

30 - 59	3
15 - 29	4
<15 (or dialysis)	5

GLU

Comment: >=200 Provisional diabetes

LIPID (Collected 11/05/13 1008, L143640-1):  
HDL

Comment: DECREASED RISK: >60 mg/dL  
AVERAGE: 40-60 mg/dL  
INCREASED RISK: <40 mg/dL

LDL

Comment: DESIRABLE: <130 mg/dL  
BORDERLINE: 130-159 mg/dL  
HIGH RISK: >159 mg/dL

CHOLESTEROL/HDL RATIO

Comment: GOAL: <5:1  
OPTIMUM: 3.5:1

COMPREHENSIVE VIEW Result View for 09/23/13 0001 - 10/27/15 0847 (Only the Results Shown on the Grid):  
Page 3

OVMC LIVE  
RESULTS BY RESULT VIEW  
Printed Tue Oct 27, 2015 8:47 AM by MGP,MVMR

Name: GOLD, KATHLEEN  
35-41  
Loc: MVHC  
Acc#: 7070879

Sex: F  
Adm: 09/19/13

DOB: 12/17/1966  
Att:

MRUN: 233-

NON-HDL CHOLESTEROL

Comment:

DESIRABLE: <130 mg/dL  
BORDERLINE: 130-159 mg/dL  
HIGH: 160-189 mg/dL  
VERY HIGH: > or = 190 mg/dL

FSH, SERUM (Collected 11/05/13 1008, L319931-1):

FSH: 45.5 mIU/mL

Comment:

Reference Range:

FEMALES:  
FOLLICULAR: 3.5-12.5 mIU/mL  
OVULATION: 4.7-21.5 mIU/mL  
LUTEAL: 1.7-7.7 mIU/mL  
POSTMENOPAUSAL: 25.8-135.0 mIU/mL

COMMENTS: NONE

ACCESSION NO. COMMENT:  
W223947

ANALYSIS PERFORMED BY:  
LOS ANGELES COUNTY-USC MEDICAL CENTER  
1200 N. STATE ST.  
LOS ANGELES, CA 90033  
PH: (323) 226-7023  
DIRECTOR: IRA A. SHULMAN, M.D.

HGB A1C (Collected 11/05/13 1008, L143638-1):

HEMOGLOBIN A1C: H 6.0 (<5.7) %

Comment:

Diabetics in good control may overlap the normal population.

American Diabetes Association (ADA) clinical practice guidelines are:

Desirable: Less than 5.7%  
Increased risk for diabetes: 5.7% to 6.4%  
Provisional diabetes: 6.5% or higher

COMPREHENSIVE VIEW Result View for 09/23/13 0001 - 10/27/15 0847 (Only the Results Shown on the Grid):